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Talking to healthcare providers about sex in later life: findings from a qualitative study with older Australian men and women

Abstract

Objective: Health Care Providers (HCPs) can play an important role in supporting the sexual health of older adults; however we know little about the experiences of older people in talking to HCPs about sex. This article examines older adults' experiences and perceptions of talking to HCPs about sex.

Methods: Semi-structured interviews were conducted with 30 men and 23 women aged 60 and older recruited from a national, online survey of older Australians. Data were analysed using a thematic approach.

Results: Most participants did not discuss sex with their HCP, and their HCP did not raise it. For those who did discuss sex with a HCP, negative and stigmatising responses were common. Positive responses could facilitate access to sexual healthcare.

Conclusions: Older people benefit when HCPs are proactive and ask about sexual health. Education in how to talk about sex with older people would also be beneficial for HCPs.

Key words: Aging, sexual health, primary care, healthcare providers

Introduction

A growing body of research evidence illustrates that many older individuals are sexually active.[1, 2] Indeed, engaging in sex is often given high importance by the 60-plus age group,[3, 4]

and ongoing sexual activity has been shown to be positively associated with a range of health and well-being outcomes.[1,2, 5-8] However, sexual activity has been associated with rising STI-rates among older individuals in recent years.[9, 29] In addition, the health-related changes that often accompany older age, such as illness and disease, and the use of particular medications, can have adverse effects on sexual function.[5] While not all older people will be sexually active, or want to be, the evidence that many do engage in sex and face a range of health-related concerns underscores the important role that healthcare providers (HCPs) can play in helping to support, or enhance, the sexual health and well-being of older people.[6, 8, 10] Indeed, HCPs are often the first point of contact for people with sexual health concerns.[11]

Open and direct discussion about sex between HCPs and older people is an important part of supporting their sexual health and well-being. Only a small body of research has been conducted to date, and it suggests that both HCPs and older people can be reluctant to initiate discussions on sex.[4-8, 12-14] A range of issues, including embarrassment, discomfort, perceiving the topic as 'intrusive' or 'inappropriate', and lack of education, time and resources, have been associated with HCPs' reticence to discuss sex with patients young and old.[7, 13, 15] HCPs may also hold ageist assumptions that older people are 'asexual' or that sex in later life is 'inappropriate', and older people can perceive that HCPs hold these assumptions.[5-8, 13 14] This suggests there may be significant barriers preventing some older individuals from accessing and receiving the sexual healthcare they need. In taking a broad approach to sexual health, and adopting the WHO definition of sexual health as a 'state of physical, mental and social well-being in relation to sexuality',[22] we recognise that promoting older people's sexual health may include supporting them to gain sexual pleasure and satisfaction in ways that do not require medical intervention.[30]

To date, there has been little research examining interactions with HCPs about sex from the patient's perspective,[12] and even less research considering the experiences of older individuals.[14] Likewise, the small body of research undertaken to date has not considered the specific socio-cultural context of older Australians. While there may be some similarities in the experiences of older adults across international settings, we cannot assume this to be the case. Qualitative research is required to provide an in-depth account of older individuals' experiences of talking (or not) to their healthcare providers about sex.[13] Documenting such experiences provides insight into the current state of practice and the conditions that promote or hinder talking about sex in healthcare settings. Examining these conditions can help to inform and improve current HCP practices in discussing sex with older people. This article aims to address this gap by providing insights from qualitative research with a sample of older Australians.

Methods

The current study was part of a larger national project, which examined older Australians' knowledge and practices of sex and sexual health.[16] The study included a quantitative survey followed by individual interviews. For the qualitative arm, and thus this paper, we adopted a constructivist epistemological approach, recognising that knowledge is contextually situated and produced. This approach focuses on the ways in which participants construct meaning (in conversation with the interviewer), rather than seeking to reveal some underlying, essential 'truth'.[23] Additionally, a life-course perspective informed our work, which positions participants' experiences within their particular social, cultural and historical contexts.[24] Drawing on the work of Calasanti and colleagues,[25] we sought to examine the experiences of participants as older people, and the ways in which age intersects with other social categories such as gender and sexuality in shaping lived-experience and possibilities for action. Ethics

approval was received from [Institutional Ethics Committee – removed for peer review] prior to initiating fieldwork.

Interviewees were recruited through the online survey sample (n=2,137). Survey participants who were interested in receiving information about the interviews were asked to provide a contact email address. This information was not stored with the survey responses. In total, 517 survey participants (24% of the survey sample) expressed interest in taking part in an interview. Every third individual who expressed interest in the interviews (n= 175), was contacted with further information about the nature and purpose of the interviews, including what participation would involve, and, of those, 53 men and women responded to the email and took part in an interview. In total, 30 men and 23 women were recruited. All participants were aged 60 and over, with the exception of two female participants who were in their mid-to-late 50s. These women were included in the sample due to challenges in recruiting women for the interview component of the study. Participants were typically highly educated and/or professionally employed (or were prior to retirement), and of Anglo Saxon background. The majority of participants were heterosexual, and currently in a relationship. An overview of the interview participants is provided in Tables 1 and 2.

[Tables 1 and 2 here]

Interview questions focused on participants' definitions of sex, sexual practices, understandings of safer sex, safer sex practices, and information-seeking practices. Participants were also asked to reflect on their comfort talking to HCPs about sexual health and sex in later life, and we predominantly draw on these findings in the following discussion. Recruitment ceased when data saturation was achieved across all major areas of interest. Interviews were

conducted by the first-named author (a young woman) via phone, Skype, or in person depending upon the participants' preference and location. Each participant was interviewed once. Interviews took between 30-60 minutes to complete on average, were digitally-recorded, and transcribed by an external agency. Transcripts were de-identified, and all participants referred to by pseudonyms. Participants had the option to review a copy of their transcript and to make corrections.

The qualitative data were analysed by the first-named author using the software package NVivo following a thematic analysis procedure.[17, 18] This process involved an initial close reading and preliminary coding of the transcripts. Notes were made identifying emerging themes, using the interview questions (e.g., 'talking to health care providers') and core study aims as initial code categories. In vivo codes were also identified based on emergent themes and patterns identified within the data (e.g., 'does not talk to HCP'). This process was then repeated in NVivo, with the data sorted into code and sub-code categories. Attention was paid to recurrent themes and patterns in the data, but also to cases that contradicted, complicated or otherwise sat outside the dominant thematic categories. This enabled us to account for the complexity and nuance in older people's experiences. A random sample of interview transcripts was independently coded by the 3rd-named author to ensure the validity of the coding, with both coders agreeing on the key thematic categories. We examined the major themes relating to participants' comfort and experiences discussing sex with their HCP.

Results

The major themes identified were: not talking to HCPs about sex, feeling comfortable talking about sex, and embarrassment talking about sex. In the following results, we also considered participants' perceptions regarding their HCPs response to discussions on sex, and the

implications of this for participants' willingness to raise sexual matters with their HCP. Participants discussed encounters with a range of different HCPs, including nurses, counsellors, and specialist medical practitioners (e.g., oncologists). However, general practitioners (GPs) were by far the most common HCP identified by participants.

Let's (not) talk about sex

The majority of participants indicated they did not talk to HCPs about sex, or that they were uncomfortable doing so. For example Beverly (age 66, heterosexual, single) recounted an experience where she wanted to ask her HCP for an STI test after experiencing "unusual" vaginal discharge, after recently ending a casual sexual relationship. However, Beverly felt unable to ask for an STI test, saying she "felt embarrassed, there's still some shame [about sex] I suppose".

Other participants reported they did not discuss sexual matters with HCPs because there was no perceived need to. This was particularly the case for participants in long-term, monogamous relationships. Norman (age 69, heterosexual, married) said that although his regular HCP asked about his sex life, they had not engaged in any extensive discussions on sexual health because "I haven't felt there's been a problem". Another participant, Dan (age 63, heterosexual, married), said he did not talk to HCPs about sexual health because he did not "go to the doctor often enough for check-ups", so there was little opportunity for him to do so.

When asked if HCPs proactively raised the topic of sex with them, participants overwhelmingly responded "no". Paul (age 67, heterosexual, married) commented that although his HCP did not actively ask him about sex, "he has signs up in his surgery saying he's quite happy to talk about sex". Another participant, Aiden (age 63, heterosexual, in a relationship), said he

personally “raise[s] it with them” because he did not have a regular GP, implying that a regular HCP would be more likely to proactively raise the issue of sex (although this did not accord with other participants’ experiences).

Participants’ beliefs about why HCPs did not actively discuss sex with them varied. Brendan (age 71, heterosexual, married) speculated about the role that gender might play, questioning whether “a woman doctor would be different” to his male HCP. Others attributed the lack of discussion to the ageist notion that older individuals do not have sex. Xavier (age 65, heterosexual married) believed that HCPs did not ask him about sex “because I’m old, when you get to a certain age people start thinking differently, it's really weird”. Edwin (age 66, heterosexual, married) believed HCPs did not proactively raise the topic of sex due to it being “embarrassing” for them. However, whether these perceptions were accurate is unclear.

Other participants indicated that although they previously never had the need to discuss sex with HCPs, they believed they would feel comfortable and able to do so if necessary. Jack (age 64, heterosexual, married) said, “I never have, but I’m sure I would feel comfortable”. Likewise, Frances (age 67, heterosexual, in a relationship) commented she had not discussed sex with her HCP “because there’s no need”. However, in the event she needed to, she said, “I guess I’d feel okay about it, but …it's untested territory really.”

Comfortable talking about sex

A small group of participants indicated they felt comfortable discussing sex with HCPs, and had direct experience in doing so. Comfort discussing sex was attributed to a range of factors, and the quality of the relationship between the participant and their HCP was central. Ivy (age 62, heterosexual, single) felt at ease discussing sex with her HCP because “she’s been my

doctor for…30 years and she's just a little bit older than me so we've gone through the same things over the years, going through menopause and all that sort of stuff, so quite comfortable asking her and just doing it." In addition to their shared experiences providing a sense of rapport, Ivy commented "I'm sexually active I have to be tested" [sic], the necessity of which also encouraged her to raise the issue of sexual health with her HCP.

Other participants approached the issue of sex and sexual health in a matter-of-fact way, and this enabled them to feel comfortable and able to raise the topic with HCPs. Opal (age 77, heterosexual, single) said of requesting an STI test "it's no trouble I just say I want a blood test". Several participants were also bolstered by the knowledge their HCP had 'progressive' views on sex. Finn (age 60, heterosexual, widow) commented that he felt comfortable discussing sex with one of his HCPs as "sexuality is one of her areas of expertise…and she deals with transgender sexuality and that sort of stuff, so I kind of feel like anything I've got to say is a bit tame to her."

Embarrassment or difficulty talking to HCP

Some participants indicated they felt embarrassed or generally found it difficult to talk to HCPs about sex, which tended to be context-dependent: influenced by the relationship between the participant and HCP. Ryan (age 65, heterosexual, single) said "my main local doctor is a male so I find that [talking about sexual health] a bit difficult I must admit." Vaughn (age 71, heterosexual, in a relationship) reported that in the past he had felt uncomfortable discussing sex. However, that changed when he "was in the sort of relationship where I wanted to do sex and I couldn't", suggesting that discomfort discussing sex is contextual and may be overcome if the need to talk to a HCP outweighs individual embarrassment. However, this may also mean that some older individuals wait until an issue is particularly pressing before consulting a HCP.

The response of HCPs to discussions about sex could in turn influence the comfort participants' felt talking about it. For example, George (age 69, heterosexual, in an open relationship) said in regards to his comfort talking about sex:

> On a scale of 10, it's in the 3, 4, 5 range. This particular GP that I have doesn't open up sexual discussion, he's not comfortable with it. My old GP in [large city] certainly was comfortable with it, I could talk to him about bits and pieces.

The findings indicated that negative responses from HCPs could play a role in shaping older peoples' ability to actively raise sexual matters. We now consider the responses our participants typically received from HCPs when talking to them about sex.

Responses of HCPs

Participants reported that responses of HCPs to discussions on sex varied: some participants reported highly positive experiences, while others were negative (e.g., stigmatising or ageist). Gwen (age 65, heterosexual, single) said she tended to 'self-censor' when she discussed sex, based on the assumption that others were more conservative than her and would not approve of her 'unconventional' sexual life. That said, Gwen's experiences with HCPs were generally positive, saying, "they're usually fine…they remain objective". Tina (age 60, heterosexual, married) also recalled that her HCP was highly positive and affirming when she requested an STI test prior to starting a new sexual relationship, saying "he was very positive, he was very supportive, he told me that I was doing absolutely the right thing."

However, several participants discussed experiences when they requested STI tests but their HCP was dismissive or discouraging. Wilma (age 61, heterosexual, widow) recalled an experience where she asked for an STI test from her HCP after having concerns about whether her current sexual partner was being faithful. However, her HCP dismissed her saying, "oh, I'm sure your fine", only agreeing to test Wilma after she insisted. Wilma suggested the HCP's dismissal of her concerns might have been based on the assumption that "I look teacherly, middle class, white…it's not going to happen to you." In contrast, the HCP who conducted Wilma's STI test was highly supportive, saying, "not enough older people come in and have this done". Indeed, several participants noted the response of HCPs appeared to be influenced by the HCPs' personal attitude, as Nicola (age 66, heterosexual, married) remarked, "it depends on the doctor".

Other participants were aware that HCPs were embarrassed or uncomfortable discussing sex with them, or anticipated they would be. Rachel (age 64, heterosexual, in a relationship) said while she was comfortable discussing sex with her HCP provider, she was "very aware that they're not, and I personally think that they're completely undereducated and it's…sometimes a bit awkward." Another participant anticipated she would be met with ageist attitudes if she discussed sex with HCPs, saying "something strange kind of seems to occur once you turn 60, and people start speaking to you more loudly…I can feel that there's an expectation again …that I behave a certain way – and I don't know…that [talking about sex] would be well received" (Karen, age 64, heterosexual, single).

For those who had raised the topic of sex with HCPs, the responses they received appeared to have profoundly influenced their willingness to discuss the topic further. Nicola (age 66, heterosexual, married) said that when:

> I'm trying to discuss something around sexual health, and I'm brushed off, I'm unlikely to discuss it further with them…Whereas if I have somebody who's open with me…and is quite happy to discuss it, even in detail for that matter, it doesn't worry me.

Nicola's point exemplifies the perspectives of other participants, therefore highlighting the central role that attitudes and approaches of HCPs towards sex in middle and later life can play.

Discussion

This study examined the experiences and perceptions of a sample of Australian men and women aged 60 and over in talking to HCPs about sex. Our findings support and extend existing research indicating that both older adults and HCPs can be reluctant discussing sex.[4-8, 12-15] To the best of our knowledge, this is the first study to document these issues within an Australian context. The majority of participants did not discuss sex with HCPs, and HCPs did not proactively raise the topic with them. Although many participants believed they would be comfortable discussing sex with HCPs, this was not based on first-hand experience of having done so, and it is unclear to what extent this perceived confidence translates into practice.[8] A range of reasons were offered for this lack of discussion about sex, including embarrassment and stigma (both of the participants and HCPs), having no perceived need to discuss sex with HCPs,[8] or believing they would receive an ageist or dismissive response.

Educative and public health initiatives are needed that work to disrupt the stigma and embarrassment associated with sex in later life. For example, campaigns that seek to normalise later life sex and encourage older individuals to raise the topic with their HCP would be useful

here. Likewise, sexual health campaigns must strive to be inclusive of older individuals, and communicate that older people are also susceptible to STIs or other sexual health related matters. Such work could be supported by, for example, ensuring that older Australians are explicitly addressed in sexual health policy, and we reiterate recent calls for such action here.[26, 27] Some participants in our study viewed sexual health as irrelevant to them, even if they were in relatively 'high risk' relationships (see authors[19]), and this likely acts as a significant barrier to discussing sex with their HCP.

For participants who did discuss sex with HCPs, the perceived willingness of HCPs to discuss sex, and their supportive and affirmative responses, could foster openness. Indeed, the perceived responses of HCPs to participants who raised the topic of sex was crucial in informing whether the consultation was a positive one, and whether the participant would continue discussing sex with HCPs. Unfortunately, many participants reported negative, dismissive, or stigmatising responses from HCPs. This is likely to have important health implications for older individuals, as such negative encounters may result in them being less likely to request an STI test or other information about sex from their HCP both now and in the future. These findings suggest that older people feel the onus is on them to navigate unspoken or spoken signals to determine if it is safe or appropriate to raise sexual issues with their HCP.

Although there were relatively minimal differences in participants' accounts based on gender, women in this study were more likely to report experiencing or anticipated receiving stigmatising and shaming responses from HCPs. In contrast, male participants were somewhat more likely to raise concerns regarding the gender of their HCP, and in particular whether a female HCP would be more receptive to discussions on sex. This suggests there may be gendered barriers to discussing sex with a HCP, and this warrants further examination,

particularly to determine the implications this presents for sexual health campaigns and HCP education. For example, some female participants reported receiving stigmatising responses from male sexual partners in attempting to discuss safer sex practices with them (authors[19]). It is unclear whether or to what extent such highly gendered experiences may in turn shape older women's willingness to discuss sex with HCPs, although several women discussed stigma and embarrassment as a barrier which suggests there may be a connection here. That is, older women's reluctance to discuss sex with HCPs may be situated within broader social norms and attitudes towards older women's sexuality, and stereotypical assumptions about who is 'likely' to contract an STI.

These findings present a number of implications for HCPs in talking to older people about sex. It is vital that HCPs are aware that older people have varying comfort levels discussing sex. HCPs need to take steps to create opportunities for older people to be able to engage in discussions about sex. This may involve, for example, proactively raising the topic of sex and sexual health with older people. Current STI screening guidelines recommend normalising conversations about sex within healthcare settings, for example by incorporating a discussion on sexual history into existing healthcare discussions.[20] Taylor and Gosney[4] also provide example questions that HCPs may use in initiating discussions on sex with older people. HCPs may benefit from routinely asking older people about their current relationship(s) and sexual activity. This could be followed up with a discussion on, for example, safer sex if the person is in a new or 'high risk' relationship. Given that many participants believed they would receive a negative or dismissive response if they attempted to talk to HCPs about sex, it is important that HCPs let older people know that they are open to discussing sex. As one participant suggested, the use of signs or posters communicating this could be effective, which echoes the findings of Dyer and das Nair.[13] Although some participants indicated they had no perceived

need to discuss sex, they still need to feel welcome to do so if they want to. It may also be beneficial for future research to examine in more detail how older people would like to broach the topic of sex with their HCP, and in particular whether they would prefer HCPs to initiate such discussions, or to do so themselves. There is unlikely to be a 'one-size-fits all' approach here, with the desires of older people (and their HCPs) shaped by a range of contextual factors and individual proclivities.

As the attitudes and characteristics of HCPs can discourage conversations on sex, there is a need to challenge the stereotypes that HCPs may hold about sex in later life and to support HCPs in appropriately discussing sex with older people. Reflexive exercises, such as those suggested by Price[21], represent a useful starting point for HCPs in identifying their own beliefs and values about sex, and in considering how these may shape their responses. Education resources for HCPs about older people and sexual health are also required in order to provide HCPs with a clear framework for initiating and responding to discussions about sex. This could be achieved by ensuring that sexual health across the life course is included in both university-level education and ongoing professional development opportunities.[27] Further, it is necessary to recognise the centrality of sexual health to overall wellbeing, rather than viewing it as an optional extra. Thus, it is important to consider and discuss with older people, for example, the impact of medications or illness on sexual functioning. Such an approach would help to position discussions on sex as a routine part of healthcare for older people. In turn, this may assist to reduce the stigma of sex in later life and embarrassment associated with talking about sex. While many of the participants in this study perceived that HCPs were reluctant or embarrassed to discuss sex, it is not clear whether this coheres with Australian HCPs experiences and perceptions of their own practice. Undertaking further research with HCPs would help to guide and inform the content and approach taken in educational efforts.

There are several limitations with this study. Participants were typically articulate, well-educated, and comfortable discussing sex in an interview context, which is likely to influence their comfort discussing sex with HCPs. The majority of participants were heterosexual, and were of an Anglo, English-speaking background which limits the transferability of the results. Future research would benefit from exploring the experiences of more diverse communities. Likewise, there were only limited differences apparent in participants' experiences and perceptions based upon gender. In order to explore this further, future research may benefit from using larger sample sizes, interrogating the role of gender more fully. Given that experiences with HCPs featured as one aspect of a broad study on sexuality and sexual health in later life, the data collected was more concerned with breadth rather than depth. While participants did discuss interactions with a range of HCPs, overall their comments were made in relation to GPs. As such, the findings presented here cannot be transferred across all HCP groups, and future research could extend these findings by examining differences between and within the diverse community of HCPs. As many of our participants (and particularly those in long-term, monogamous relationships) had not discussed sex with a HCP, this presented a challenge in collecting detailed data pertaining to their experiences. While this finding is insightful in itself, future research could benefit from a more focused exploration of the experiences of older individuals who have discussed sex with a HCP. Finally, the majority of our participants were aged in their 60s and 70s, so our findings can only provide limited insight into the experiences of those in 'deeper' old age.

Conclusion

We encourage HCPs to reflect on their current practice and attitudes when it comes to ageing and sex, and to take the initiative to raise the issue with older people (whilst recognising the

role of older people themselves in raising the topic when they have sexual health concerns). This should help those older people who wish to discuss sex but require a more direct approach from their HCP.

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References

1. Lindau ST, Schumm LP, Laumann EO, Levison W, O'Muircheartaigh CA, Waite L. A study of sexuality and health among older adults in the United States. New England Journal of Medicine. 2007; **357**: 538-543.
2. DeLamater J. Sexual expression in later life: a review and synthesis. Journal of Sex Research. 2012; **49**: 125-141.
3. Fileborn B, Thorpe R, Hawkes G, Minichiello V, Pitts M, Dune T. Sex, desire, and pleasure: considering the experiences of older Australian women. Sexual and Relationship Therapy. 2015; **30**: 117-130.
4. Taylor A, Gosney MA. Sexuality in older age: essential considerations for healthcare professionals. Age & Ageing. 2011; **40**: 538-543.
5. Bauer M, Haesler E, Fetherstonhaugh, D. Let's talk about sex: older people's views on the recognition of sexuality and sexual health in the health-care setting. Health Expectations. 2015; **19**: 1237-1250.

6. Gott M, Hinchliff S, Galena E. General practitioner attitudes to discussing sexual health issues with older people. Social Science & Medicine. 2004; **58**: 2093-2103.
7. Hinchliff S, Gott M. Seeking medical help for sexual concerns in mid- and later life: a review of the literature. Journal of Sex Research. 2011; **48**: 106-117.
8. Hughes AK, Lewison TDW. Facilitating communication about sexual health between aging women and their health care providers. Qualitative Health Research. 2015; **25**: 540-550.
9. Poynten IM, Grulich AE, Templeton DJ. Sexually transmitted infections in older populations. Current Opinion in Infectious Diseases. 2013; **26**: 80-85.
10. Hughes AK, Rostant OS, Curran PG. Improving sexual health communication between older women and their providers: how the integrative model of behavioural prediction can help. Research on Aging. 2014; **36**: 450-466.
11. Gott M, Galena E, Hinchliff S, Elford H. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. Family Practice. 2004; **21**: 528-536.
12. Adams SA. Marital quality and older men's and women's comfort discussing sexual issues with a doctor. Journal of Sex & Marital Therapy. 2014; **40**: 123-138.
13. Dyer K, das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. Journal of Sexual Medicine. 2013; **10**: 2658-2670.
14. Gott M, Hinchliff S. Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. Family Practice. 2003; **20**: 690-695.
15. McGrath M, Lynch E. Occupational therapists' perspectives on addressing sexual concerns of older adults in the context of rehabilitation. Disability & Rehabilitation. 2014; **36**: 651-657.

16. [Authors et al, Culture, Health & Sexuality – removed for peer review]
17. Ezzy D. Qualitative analysis: practice and innovation. 2002. London: Routledge.
18. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; **3**: 77-101.
19. [Authors et al, Journal of Sex Research – removed for peer review]
20. Australian STI management guidelines for use in primary care [Internet]. Australasian Sexual Health Alliance.Taking a sexual history and contact tracing [cited 2016 Aug 25]. Available from: http://www.sti.guidelines.org.au/resources/how-to-take-a-sexual-history#how-to-take-a-sexual-history
21. Price B. Exploring attitudes towards older people's sexuality. Nursing Older People. 2009; **21**: 32-39.
22. World Health Organisation. Defining sexual health: report of a technical consultation on sexual health 28-31 January 2002, Geneva. 2006. WHO.
23. Charmaz, C. Constructing grounded theory: a practical guide through qualitative analysis. 2006; London: SAGE.
24. Ballard, S.M., and Morris, M.L. The family life education needs of midlife and older adults. Family Relations. 2003; **52**: 129-136.
25. Calasanti, T., Slevin, K.F., & King, N. Ageism and feminism: from "et cetera" to center. NWSA Journal. 2006; **18**: 13-30.
26. Kirkman, L., Fox, C., & Dickson-Swift, V. A case for sexual health policy that includes midlife and older adult sexuality and sexual health. The International Journal of Aging and Society. 2016; **6**: 17-27.
27. Coleman, E., Elders, J., Satcher, D., Shindel, A., Parish, S., Kenagy, G., … & Lunn, M.R. Summit on medical school education in sexual health: a report of an expert consultation. The Journal of Sexual Medicine. 2013; **10**: 924-938.

28. Fileborn.B., Lyons, A., Hinchliff, S., Brown, G., Heywood, W., Dow, B., Malta, S., & Minichiello, V. Improving the sexual lives of older Australians: perspectives from a qualitative study. Australasian Journal on Ageing. Forthcoming.
29. Bourne, C., & Minichiello, V. Sexual behaviour and diagnosis of people over the age of 50 attending a sexual health clinic. Australasian Journal on Ageing. 2009; **28**: 32-36.
30. Gott, M. Sexuality, sexual health and ageing. 2005. England: Open University Press.

Table 1: Overview of interview participants.

	Male participants	Female participants
	N=30	N=23
Characteristic		
Sexual orientation		
Heterosexual	27	20
Gay/Lesbian	1	1
Bisexual	2	2
Current relationship status		
Married	13	5
In a relationship	7	6
Single	5	8
In an open relationship/multiple partners	4	2
Widow	1	2

Table 2. Interview participants' age

	Number of participants	
Age range	**Men**	**Women**
55-59	-	2

60-69	21	16
70-79	8	5
80+	1	-